Table 1 Patient details

Patient No	Age (years)	Smoker	Referral source	Referral diagnosis	Presenting features	Urine dipstick	Urine cytology	Diagnosis and treatment
1	26	NR	GP	?Infection	3 months intermittent painless haematuria	Blood +ve (trace)	ND	Well differentiated bladder papillary TCC; non-invasive; resected
2	34	Yes	GP	?Urethritis	6 weeks frequency, dysuria	Blood +ve	ND	Poorly differentiated adenocarcinoma; bladder calculus also present; tumour resection, chemotherapy, and radiotherapy
3	53	No	GP	Recurrent prostatitis	1 year penile and suprapubic pain; frequency, dysuria	Blood +ve	Malignant	Extensive transitional cell carcinoma in situ, involving prostatic urethra; cystoprostatectomy
4	42	No	GP	Sterile pyuria ?cause	1 year penile and perineal pain, frequency, dysuria	Blood +ve (trace)	Malignant	Extensive TCC plus carcinoma in situ, involving prostatic urethra; cystoprostatectomy
5	50	Yes	GP	?Infection	6 weeks frequency, urgency, dysuria	Blood +ve	Suspicious	Poorly differentiated TCC at bladder neck; muscle invasion; cystoprostatectomy, and chemotherapy

NR = not recorded; ND = not done; TCC = transitional cell carcinoma.

genitourinary infection, rather than suspected neoplasia, because of his young age (26 years).

Bladder neoplasia is especially liable to cause irritative symptoms when represented by, or associated with, carcinoma in situ of the bladder urothelium.[1 2] Urine cytology may be useful in this subgroup, and was abnormal in all three of the five patients in whom it was requested. When this process involves the prostatic urethra, symptoms mimicking prostatitis may arise. Early diagnosis of bladder neoplasia is of prognostic importance; the presence of carcinoma in situ or prostatic involvement by bladder carcinoma are poor prognostic features for which radical surgery may be required.[1 4]

These cases highlight the importance of careful follow up of patients presenting with persistent irritative-type bladder symptoms, especially in an older age group, when specific tests for genitourinary infection are negative, and where microscopic haematuria is a feature. Bladder carcinoma should be considered in this subgroup; urine cytology and referral for cystourethroscopy may be indicated. Although rare in younger adult males, bladder cancer should not be ruled out in men under the age of 45 years, and our experience strengthens the case for continuing with routine urine testing in genitourinary medicine clinics.

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Atrial myxoma and HIV infection

EDITOR,—Atrial myxoma has not previously been reported in HIV infection. We describe a patient with advanced HIV disease who underwent surgery for this condition.

The patient was diagnosed with asymptomatic HIV infection in February 1987 when she was aged 50 years. Her CD4 count was 690 $\times 10^6$/l at this time. HIV infection was acquired through sexual intercourse with a bisexual male partner. In December 1990 the CD4 lymphocyte count had fallen to 190 $\times 10^6$/l and zidovudine monotherapy was started. This was continued until 1996 when she was prescribed a combination regimen. Co-trimoxazole was given for *Pneumocystis carinii* prophylaxis, but the patient deferred starting this until December 1992.

In February 1992 the patient was admitted to another hospital with an acute myocardial infarction which was successfully thrombolysed. Fasting lipids were within the normal range. There were no cardiac risk factors apart from smoking.

In September 1995 the patient experienced a syncopal episode. An echocardiogram revealed a mass in the left atrium consistent with a left atrial myxoma. A coronary angiogram showed normal coronary arteries. Surgical resection of the myxoma was recommended.

In December 1995 the patient's CD4 count was 64 $\times 10^6$/l, but apart from oral candidiasis there had been no HIV related problems since diagnosis. Two leading UK HIV physicians were asked if they considered surgery to be advisable. They estimated the patient's likely survival from HIV disease to be 1–4 years. The risks of major heart surgery had to be balanced against the likelihood of recurrent symptoms from the myxoma in the next 1–4 years. The patient and her physician agreed to proceed with surgery.

On 4 December 1995 the patient underwent surgical resection of a pedunculated left atrial mass. Histological examination confirmed a benign atrial myxoma. The procedure was uncomplicated and she was discharged from hospital 4 days later. Annual cardiac review including an echocardiogram has shown no evidence of recurrence up to the present time. She remains free from cardiovascular symptoms. Her HIV disease is managed with combination therapy that consists of stavudine, lamivudine, and efavirenz. Current CD4 count is 564 $\times 10^6$/l and viral load less than 50 copies/ml (Chiron bDNA v3.0)

Atrial myxoma is a rare tumour that is considered to be benign although recurrence and metastases have been described.[1] The myocardial infarction suffered by our patient may have been an embolic manifestation of the myxoma, and the normal serum lipids and normal coronary angiogram almost 4 years later would support this.

In 1995 expert opinion provided a very guarded prognosis for someone with a CD4 count of 60 $\times 10^6$/l who had been exposed to a single antiretroviral agent, zidovudine. Today there would be less debate over the merits of such a surgical procedure in this scenario, and this case demonstrates the excellent outcome that can be achieved with major surgery despite profound immunosuppression. The proved benefits of HAART (highly active antiretroviral therapy) have made it unacceptable to deny major surgical interventions to individuals with HIV.

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The association between receptive cunnilingus and bacterial vaginosis

EDITOR,—We are puzzled by the surprisingly little, if any, serious work done to explain the epidemiological enigma of high prevalence of bacterial vaginosis (BV) in lesbians,[1] and the oft observed, but as yet unconfirmed association between BV and receptive cunnilingus in women in general.

In a detailed study of 17 consecutive lesbians attending the department of genitourinary medicine at the Royal Sussex County Hospital in Brighton, bacterial vaginosis was found in six women (35%). Of nine lesbians who practised receptive cunnilingus in the previous 4 weeks, six (67%) had BV. By contrast, no BV was present in all eight women who did not practise oral sex (table 1).

In a parallel prospective study of 256 consecutive heterosexual female patients attending the same department, 55 (21%) were diagnosed as having BV. Of 111 women who practised receptive cunnilingus in the previous 4 weeks, 41 (37%) had BV. Of 145 women who did not have oral sex, only 14 (10%) had BV (table 1). In both groups there was strong association between BV and receptive cunnilingus ($p<0.001$).

The evidence associating bacterial vaginosis with oral sex is too strong to be ignored and repeatedly dismissed. The mouth is full of Gram positive and Gram negative organisms including *Bacteroides oralis* and, albeit in much smaller quantities, lactobacilli. These organisms are part of normal flora in the mouth, but are they normal to the vagina? Might the tiny amount of lactobacilli be enough to act as a phage which destroys the